

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1803742
3756 CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Kent		MARYLAND		STATE Maryland COUNTY Kent			
CITY (If outside corporate limits, write RURAL OR and give nearest town) X Chesterville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chesterville		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		1	
3. NAME OF DECEASED: (First) (Middle) (Last) Paul John Antone				4. DATE (Month) (Day) (Year) OF DEATH: 4/9/55 19			
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Mar. 5, 1908	9. AGE last birthday: 47 yrs.	10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Kent Co. Md.	
13. FATHER'S NAME: Matt Antone				14. MOTHER'S MAIDEN NAME: Annie Nickerson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218-03-3262			
				17. INFORMANT & ADDRESS: Anna Mae Antone wife Chesterville, Md			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 420.1 Coronary occlusion						12 days	
ANTECEDENT CAUSE (S) DUE TO (B) Degeneration of the heart muscle						2	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Lesions of the coronary artery						2	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 23, 1955 , to Apr 9, 1955 , that I last saw the deceased alive on Apr 9, 1955 , and that death occurred at 8:45 P. M. from the causes and on the date stated above.							
SIGNATURE John L. ...				ADDRESS Middleton		DATE SIGNED 4.10.55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/12/1955		NAME OF CEMETERY OR CREMATORY WESLEY Chapel CEM		LOCATION (City, town, or county) (State) ROCKHALL Md	
DATE REC'D BY LOCAL REGISTRAR April 10, 1955		REGISTRAR'S SIGNATURE Edward ...		24. FUNERAL DIRECTOR ADDRESS J. Willis Wells Chestertown, Md.			

BUREAU V. S.

APR 14 1955

RECEIVED

3757

MARYLAND STATE DEPARTMENT OF HEALTH

03743

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 202

1. PLACE OF DEATH- COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Kent	
CITY (If outside corporate limits, write RURAL and OR give nearest town) X TOWN Chestertown		LENGTH OF STAY (In this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Farm - near Fairlee, Md. X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Farm near Fairlee				STREET ADDRESS (If rural, give location) Chestertown, RFD	
3. NAME OF DECEASED (Type or Print)		(First) George (Middle) T. (Last) Berger		4. DATE OF DEATH Apr. 4, 1955 19	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 5/25/1888	9. AGE last birthday 66 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Manager		11. BIRTHPLACE (State or foreign country) Kent Co. Md.	
13. FATHER'S NAME Thomas Berger		14. MOTHER'S MAIDEN NAME Alice Davis		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. don't know		17. INFORMANT AND ADDRESS wife Mrs. Mary Berger Chestertown, Md.	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

928.1
Immediate cause(a) *multiple severe crushing injuries*

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) *to thorax & abdomen*Interval Between Onset and Death
don't know

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		PLACE (Home, farm, factory, street, office, etc.) INJURY Farm	(CITY OR TOWN) Chestertown	(COUNTY) Kent	(STATE) Md
TIME (Month) (Day) (Year) (Hour) OF INJURY 4 4 558-82		INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? attacked by bull -		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 4/6/1955	NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.	LOCATION (City, town, or county) Rock Hall, Md.	(State)
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DATE REC'D BY LOCAL REG. April 5, 1955	REGISTRAR'S SIGNATURE Clara L. Barnes	24. FUNERAL DIRECTOR J. Willis Wells	ADDRESS Chestertown, Md
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 11 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH- COUNTY <u>KENT</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - CHESTERTOWN</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>NEAR POMONA</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>KENT</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - CHESTERTOWN</u> STREET ADDRESS <u>NEAR POMONA</u>	
3. NAME OF DECEASED (Type or Print) <u>CARL CHRISTIAN DOLL</u>		4. DATE OF DEATH (Month) <u>APRIL</u> (Day) <u>12</u> (Year) <u>1955</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>AUG 13, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>MOULDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FOUNDRY</u>	9. AGE last birthday <u>63</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S. BORN</u>	
13. FATHER'S NAME <u>CHRISTOPHER DOLL</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET BORST</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) <u>YES</u> (If yes, in what service) <u>WORLD WAR I</u>		16. SOCIAL SECURITY No. <u>- 342-10-2503</u>	
17. INFORMANT AND ADDRESS <u>WIFE OF DECEASED</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Carcinomatosis</u>		<u>3 - 4 month</u>	
(b) Antecedent cause(s) <u>Adeno Carcinoma of rectum</u>		<u>several months</u>	
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? <u>X</u> Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/2</u> , 19 <u>55</u> , to <u>4/12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/12</u> , 19 <u>55</u> , and that death occurred at <u>7:40 PM</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Robert W. Farr</u>		ADDRESS <u>Chestertown, Md.</u> DATE SIGNED <u>4/14/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Apr. 15, 1955</u> NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u> LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>April 14 1955</u>		24. FUNERAL DIRECTOR <u>J. Willis Wells - Chestertown, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 18 1955

RECEIVED

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3759				03745			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 200							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Millington</u>		<u>Life</u>		TOWN <u>Millington</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Road East of Millington, Md.</u>				STREET ADDRESS (If rural, give location) <u>R.D. 2</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>George</u>		(Middle) <u>Howard</u>		(Last) <u>GREEN</u>		4. DATE OF DEATH <u>4 9 1955</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Col.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>12-28-1912</u>	
9. AGE last birthday: <u>42 yrs.</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>FARM</u>		11. BIRTHPLACE (State or foreign country): <u>Millington, Kent Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Howard George GREEN</u>				14. MOTHER'S M maiden NAME: <u>Hester Ann Newcomb</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY No.: <u>213-24-1014</u>		17. INFORMANT & ADDRESS: <u>Wm. Alexander Green R.D. 2 - Millington, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>22 CAL. bullet wound in the head -</u>						<u>Instantly</u>	
DUE TO <u>(head) parietal region - inch lateral to vertex</u>							
Antecedent cause(s) (b) <u>parietal</u>							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>NONE</u>							
19a. DATE OF OPERATION: <u>NONE</u>				19b. MAJOR FINDING OF OPERATION: <u>Dead know</u>			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>At home</u>		21c. (City or town) (County) (State)			
<u>Millington Kent Md.</u>							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4 9 1955 9:45 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Homicide. Shot by 22 caliber weapon</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Robert W. Jones</u>				M. D. ASSISTANT MEDICAL EXAM. <u>4-13-1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>4-13-55</u>		NAME OF CEMETERY OR CREMATORY <u>Guy's Chapel Cemetery Near Millington Md.</u>		LOCATION (City, town or county) (State) <u>Chesapeake Md.</u>	
DATE REC'D BY LOCAL REG. <u>April 13, 1955</u>		REGISTRAR'S SIGNATURE <u>Edward Fellows</u>		24. FUNERAL DIRECTOR <u>Marvin V. Williams</u>		ADDRESS <u>Chesapeake Md.</u>	

BUREAU V. S.

APR 18 1955

RECEIVED

3760

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Millington</u>				OR TOWN <u>Millington</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) <u>Russell</u> (Middle) <u>I.</u> (Last) <u>Hare</u>				OF DEATH: <u>4/ 21/19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>married</u>	<u>March 24 1892</u>	<u>73</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Lawyer</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Ohio</u>	
13. FATHER'S NAME: <u>Albert J. Hare</u>				14. MOTHER'S MAIDEN NAME: <u>Henrietta Ingmann</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Florence Hare Millington MD.</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>Was paralyzed since onset and had several attacks</u>			
334X IMMEDIATE CAUSE (A) <u>Apoplexy</u>				<u>1942</u>			
ANTECEDENT CAUSE (B) <u>Nephritis</u>				<u>for years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertension</u>				<u>for 20 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12: 8</u> , 19 <u>54</u> to <u>April 21, 1955</u> ; that I last saw the deceased alive on <u>April 17</u> , 19 <u>55</u> , and that death occurred at <u>3: P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Edmund Kowalewski</u>				ADDRESS <u>Millington Md</u>		DATE SIGNED <u>4.22.55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/26/55</u>		<u>Logan Cemetery</u>		<u>Logan, Ohio</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR'S ADDRESS			
<u>April 22, 1955</u>		<u>Edward Bellows</u>		<u>Edward Bellows Millington Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 26 1955

RECEIVED

3753

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
37 TOWN <u>Chesapeake</u>		<u>8 days</u>		<u>Kennedysville</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
72 <u>Kentland Green Arms Hospital</u>				<u>/</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First)		(Middle)		(Last)			
(Type or Print)		<u>William M.</u>		<u>Hurlock</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>Widowed</u>		<u>May 6, 1871</u>	
9. AGE last birthday				10. DATE OF DEATH:			
<u>83</u> yrs.				<u>April 7 1955</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
<u>Farmer</u>				<u>Farming</u>			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<u>MARYLAND</u>				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>WM. J. HURLOCK</u>				<u>MARY JANE GORDON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>no</u>				<u>215-26-4869</u>			
17. INFORMANT & ADDRESS:							
<u>Elizabeth H. Fowler</u>				<u>Still Pond, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
416X IMMEDIATE CAUSE						<u>26 hours</u>	
(A) <u>Circulatory collapse</u>							
DUE TO							
ANTECEDENT CAUSE (S)						<u>Several years</u>	
(B) <u>Uterine cancer</u>							
DUE TO							
(C) <u>Old rheumatic heart disease</u>						<u>Several years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>10 days</u>	
<u>Chronic, urinary retention, enlarged prostate, bilateral hernia, senility</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-31</u> , 19 <u>55</u> , to <u>4-7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-7</u> , 19 <u>55</u> , and that death occurred at <u>2:10</u> P M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>A. C. Smith</u>				<u>M. D. Chesapeake, Md</u>		<u>4-7-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 10, 1955</u>		<u>Galena Cemetery</u>		<u>Galena Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4/10/55</u>		<u>E. J. Gennard Jones</u>		<u>B. R. Fellows</u>		<u>Still Pond, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Circulatory Collapse

Myocarditis

Old rheumatic Heart disease

Uremia - Urinary retention enlarged prostate

bilateral hernias, senility

RECEIVED

APR 13 1955

BUREAU V. S.

MARYLAND

STATE DEPARTMENT OF HEALTH

3761

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Georgetown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Georgetown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Georgetown</u>		STREET ADDRESS (If rural, give location) <u>Georgetown</u>	
3. NAME OF DECEASED (First) <u>S.</u> (Middle) <u>1 Herman</u> (Last) <u>McCauley</u>		4. DATE OF DEATH <u>Apr. 30</u> 19 <u>53</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 29, 1883</u> 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>J. Bernard McCauley</u>		14. MOTHER'S MAIDEN NAME <u>Clara Woodall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>212-03-3430</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Margaret W. McCauley - Georgetown, Md.</u>			

15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause <u>420.0</u> (a) <u>Acute Myocardial Infarction</u>		<u>5 min.</u>
Antecedent cause(s) (b) <u>Coronary Occlusion</u>		<u>5 min.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerotic Heart Disease</u>		<u>3 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 28, 1955, to Apr. 30, 1955, that I last saw the deceased

alive on Apr. 30, 1955, and that death occurred at 9:00 m., from the causes and on the date stated above.

SIGNATURE Wallace Oshenchain, M.D. (Degree or title) ADDRESS Cecilton, Md. DATE SIGNED 30 April 55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>May 2, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Galena Cemetery</u>	LOCATION (City, town, or county) (State) <u>Galena Kent Co. Md.</u>
DATE REC'D BY LOCAL REG. <u>May 1, 1955</u>	REGISTRAR'S SIGNATURE <u>Elyabeth J. Mulford</u>	24. FUNERAL DIRECTOR <u>Marion W. Welham - Chestertown Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 3 1935

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3754

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03749

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH: COUNTY <u>KENT</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u> OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>KENT + QUEEN ANNE'S HOSP.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>BALTIMORE</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WORTON (RURAL)</u> STREET ADDRESS (If rural give location) <u>WORTON POINT</u>	
3. NAME OF DECEASED: (Type or Print) (First) <u>MARGARET</u> (Middle) <u>MYERS</u> (Last) <u>MYERS</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>APRIL 9</u> 19 <u>55</u>	
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. <u>SINGLE</u> <u>MARRIED</u> <u>WIDOWED</u> <u>DIVORCED</u> (Specify):	8. DATE OF BIRTH: <u>MAY 17, 1878</u>
9. AGE last birthday <u>76</u> yrs.		10. CITIZEN OF WHAT COUNTRY: <u>U.S. BORN</u>	
11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S. BORN</u>	
13. FATHER'S NAME: <u>JOHN YOUNGER</u>		14. MOTHER'S MAIDEN NAME: <u>JARAH GEPHART</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS: <u>HOSPITAL RECORDS</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.0</u> IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC HEART DISEASE - UNKNOWN</u> DUE TO ANTECEDENT CAUSE (B) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAR 3, 1955</u> , to <u>APRIL 9, 1955</u> , that I last saw the deceased alive on <u>APRIL 8, 1955</u> , and that death occurred at <u>6:00</u> M, from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> M.D. <u>Chestertown</u> DATE SIGNED <u>4-9-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4-12-55</u>	
NAME OF CEMETERY OR CREMATORY <u>CHESTER CEMT</u>		LOCATION (City, town, or county) (State) <u>CHESTERTOWN MD.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>B.R. FELLOWS STILL POND, MD.</u>			

RECEIVED

APR 13 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3755 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03750

CERTIFICATE OF DEATH

Reg. Dist. No. 201.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>KENT</u>	MARYLAND	STATE <u>MARYLAND</u> COUNTY <u>KENT</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>CHESTERTOWN</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BETTERTON</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>KENT & QUEEN ANNES</u>		STREET ADDRESS (If rural give location)	1
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>CHARLES E. RICE JR.</u>		<u>April 9 1955</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>JAN. 24, 1892</u>
9. AGE last birthday: <u>63</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>FIREMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>RAILROAD</u>	
11. BIRTHPLACE (State or foreign country): <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>CHARLES E. RICE SR.</u>		14. MOTHER'S MAIDEN NAME: <u>ANNA MAY MILLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>715-18-3669</u>	
17. INFORMANT & ADDRESS: <u>HOSPITAL RECORDS</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
331X IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u>			<u>1 day</u>
ANTECEDENT CAUSE (S) (B) <u>arteriosclerosis, generalized</u>			<u>10 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pneumonia</u>			<u>2 weeks</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 28, 1955</u> , to <u>April 9, 1955</u> , that I last saw the deceased alive on <u>April 9, 1955</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>F. Bruce Chandler</u>		ADDRESS <u>Worton, Md.</u>	
DATE SIGNED <u>April 11, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4-11-55</u>	
NAME OF CEMETERY OR CREMATORY <u>STILL POND CEMTY</u>		LOCATION (City, town, or county) (State) <u>STILL POND MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/11/55</u>		REGISTRAR'S SIGNATURE <u>E. Kennard Jones</u>	
24. FUNERAL DIRECTOR <u>B. R. FELLOWS</u>		ADDRESS <u>STILL POND, MD.</u>	

RECEIVED

APR 3 1935

BUREAU

V. S.

Cerebral Vascular accident
Arteriosclerosis generalized
Pneumonia

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				037513	
Item 18 Film G182 6-17-55 ams				3762	
CERTIFICATE OF DEATH				Reg. Dist. No. 25	
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Kent MARYLAND			STATE Maryland COUNTY Kent		
CITY (If outside corporate limits, write RURAL OR and give nearest town) Rock Hall			CITY (If outside corporate limits, write RURAL and give nearest town) Rock Hall		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED: (First) Edward (Middle) Millard (Last) Rodney			4. DATE (Month) (Day) (Year) OF DEATH: April 19 19 55		
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower	8. DATE OF BIRTH: Nov. 26-1879		9. AGE last birthday 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland	
13. FATHER'S NAME: Edward Rodney		14. MOTHER'S MAIDEN NAME: Henrietta Downey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: Walter R. Rodney--Rock Hall, Md.	
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) Coronary Thrombosis					48 hours
ANTECEDENT CAUSE (S)					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.					
(B) Massive pleural effusion					weeks (?)
(C) Possible tuberculosis (awaiting report of Report Negative culture of fluid)					unknown
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from March 1, 1955 , to April 19, 1955 , that I last saw the deceased alive on April 19, 1955 , and that death occurred at 1:00 P.M. from the causes and on the date stated above.					
SIGNATURE Millard F. Smith MD		ADDRESS Rock Hall, Md.		DATE SIGNED 4/21/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF April 21		NAME OF CEMETERY OR CREMATORY Wesley Chapel	
LOCATION (City, town, or county) Rock Hall, Md.		(State)			
DATE REC'D BY LOCAL REGISTRAR April 21-1955		REGISTRAR'S SIGNATURE S. Edward Singer		24. FUNERAL DIRECTOR Edgar L. Lane ADDRESS Church Hill, Md.	

15.00
 1.10
 15.00
 1.9

5.00
 1.10
 5.00
 7.0

✓

BUREAU V. S.

MAY 3 1905

RECEIVED

3763

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Near Millington</u>		<u>39yrs.</u>		TOWN <u>Rural Millington</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>James</u> <u>Toth</u>				OF DEATH: <u>April 6</u> <u>19</u> <u>55</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH: <u>Sept 2, 1976</u>	
9. AGE last birthday <u>78</u> yrs.		10. AGE last birthday <u>78</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>own farm</u>			
13. FATHER'S NAME: <u>James Toth Sr.</u>				14. MOTHER'S MAIDEN NAME: <u>Susan Sipos</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS: <u>Rosa Toth Millington Md.</u>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>							
ANTECEDENT CAUSE (S) DUE TO <u>Coronary sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Degeneration of the heart muscle -</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 2, 1955</u> , to <u>April 6, 1955</u> , that I last saw the deceased alive on <u>April 5, 1955</u> , and that death occurred at <u>7:15 A. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Ulfar Komlevski</u>				ADDRESS <u>M.D. Millington Md</u>		DATE SIGNED <u>4-7-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/9/55</u>		<u>Millington Cem.</u>		<u>Millington Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>April 8 1955</u>		<u>Edward Fellows</u>		<u>Edward Fellows</u>		<u>Millington Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 14 1955

BUREAU V. B.

3764

CERTIFICATE OF DEATH

Reg. Dist. No. 200...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>KENT</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>KENT</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>MILLINGTON</u>		OR TOWN <u>MILLINGTON</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
		<u>1</u>	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First)	(Middle)	(Last)	OF DEATH: <u>APRIL 26 1955</u>
<u>HARRY</u>	<u>J.</u>	<u>TOULSON</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>JAN. 22, 1975</u>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<u>80</u> yrs.		<u>MD.</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>MD.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>WILLIAM J. TOWLSON</u>		<u>CHARLOTTE FAULKNER</u>	
15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		<u>179-12-8486</u>	
17. INFORMANT & ADDRESS:			
<u>MRS. LEONARD WILSON, MILLINGTON, MD.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>		<u>3 1/2 hours</u>
ANTECEDENT CAUSE (B) <u>Hypertension</u>		<u>2</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 25, 1955, to Apr. 25, 1955, that I last saw the deceased alive on Apr. 25, 1955, and that death occurred at 1 A. M, from the causes and on the date stated above.

SIGNATURE <u>Edna K. Kneale</u>		ADDRESS <u>Millington</u>		DATE SIGNED <u>4-26-55</u>
M. D.				
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY
<u>BURIAL</u>		<u>4/28/55</u>		<u>MILLINGTON CEM.</u>
LOCATION (City, town, or county) (State)				
<u>MILLINGTON, KENTCO. MD.</u>				
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR
<u>4/26/55</u>		<u>Edward Fellows</u>		ADDRESS <u>Millington, Md.</u>

MARGIN RESERVED FOR BINDING

BUREAU V. 3

MAY 2 1955

RECEIVED